CRITICAL EYE

Issue 18 | Autumn 2020

The Faculty of Intensive Care Medicine™

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WELCOME

Dr John Butler
Clinical Editor

In 2020 the NHS has faced the greatest challenge since its inception in 1948. The COVID-19 pandemic has brought unprecedented demands with considerable impacts on Intensive Care services, both nationally and globally. Never before have we needed to change our working patterns so radically in such a short period of time. Not only have we seen a massive increase in the numbers of patients, a surge in the intensity of work, difficulties with working conditions and changes to rotas, but study leave, teaching, courses and exams have also been cancelled. This has been an enormous challenge and our specialty should be rightly proud of the incredible way in which we have responded. The unparalleled commitment and flexibility of the NHS staff has supported the remarkable NHS response to the greatest global health emergency in our history. Despite the colossal levels of disruption there have been many excellent examples of teamwork, innovation, excellence in practice and leadership demonstrated throughout our specialty. A small number of examples are included in this edition of critical eye with more to follow in the winter edition.

The disruption caused by the pandemic has led to inevitable unavoidable consequences. Regrettably, the Faculty Board was left with no choice but to postpone our 10 year anniversary celebrations until 2021, to postpone the annual meeting, and cancel interviews and exams. Sadly COVID-19 looks set to be with us for some time to come, so we will need to remain vigilant but rest assured that normal service will be resumed as soon as possible.

Despite the challenges of 2020 there are many notable triumphs to commend, including the news that Health Education England has funded more than 100 additional training numbers, spread across four nations, giving us the biggest cohort by far, of newly appointed ICM trainees this year. In addition, the GMC have now approved the new curriculum rewrite and a huge amount of credit should go to the Curriculum Working Party for all of their efforts. In July we launched the '2020 vision: Arms around the world', a collaboration of learning and wellbeing with the College of Intensive Care Medicine in Australia and New Zealand. This initiative will enhance the sharing of ideas and education between nations, enabling us to continue to provide high quality care to our patients.

I hope you enjoy reading this edition and please stay safe. We welcome any ideas for future articles. Please send your comments to contact@ficm.ac.uk.

Please visit our website for the latest news:
https://www.ficm.ac.uk/news-events-education

Administered & Designed by Mrs Dawn Evans

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MESSAGE FROM THE DEAN

Dr Alison Pittard

I read through my last message before writing this article. I said: "it is really exciting for me to be Dean during our 10th anniversary year" and how I wanted "to promote our specialty around the globe". I'm not sure I still agree with the first quote, but our uninvited guest has certainly put our specialty under the spotlight. I am immensely proud of how everyone has worked together to deliver the best possible care to our patients, and the way in which collaboration and mutual support across all healthcare professions has become a new norm.

Everyone's professional and personal experience has been unique; some have risen to the challenge and flourished whilst others have struggled, especially our colleagues in other specialty areas who wouldn't normally be exposed to this degree of severity of illness or mortality. The health and wellbeing of staff is paramount; if we can look after each other we can do the job we have been trained to do. Of course this is one of the aims of 'The People Plan', along with recruiting and retaining a healthcare workforce for the future. Please pass on my gratitude to your non-critical care colleagues who helped during the first surge. The world is a different place now but we are definitely better together.

New ways of working

I am an optimist and I can certainly see opportunities as a result of COVID-19. We delayed publication of our Enhanced Care guidance in March but, saw it as a way of harnessing the rapid training and education that was taking place at the time. Enhanced Care (EC) will require these skills to help restore services and improve pathways for patients going forward. It will also create some system resilience in terms of maintaining elective pathways during periods of increased demand on the NHS. Because of this, we decided to publish our guidance in May. NHSE have been supportive and we have collaborated with them, the Centre for Perioperative Care, and others to develop a framework for implementing perioperative enhanced care. This will not only support elective care, but liberate some critical care capacity and help to maintain team skills should a further redeployment be necessary. Other areas that will benefit from EC are respiratory units, who obviously came into their own during the first surge, and Long Term Ventilation units. There is also an opportunity to embed enhanced maternal care to ensure that pregnant and recently pregnant women continue to receive the care they need. Alongside this, as the body responsible for training in Intensive Care Medicine, we are developing a curriculum in Enhanced Care.

As part of this new service delivery, HEE recognise that training the multi professional workforce will be crucial to its success. Since the change to curricula in internal medicine and physician specialties, we have struggled to find a solution to maintain the ability to also train in ICM. COVID-19 has highlighted the importance of generic critical care skills and there is ongoing dialogue between FICM, the JRCPTB, HEE and the GMC. By the time you read this we will have already submitted our new curriculum to the GMC for approval so hopefully this issue will have been resolved.

New beginnings

In July we officially launched '2020 Vision: Arms Around the World', a collaboration for learning and wellbeing with the College of Intensive Care Medicine in Australia and New Zealand. This is an exciting opportunity to build on our common goals of training and education, recognise and encourage diversity, and strive for equity. Building resilience through this initiative will allow us to continue to provide consistently high quality care, whilst sharing ideas to face and learn from unprecedented global challenges. Again the launch had been postponed but we felt the time was right and Dr Rob Bevan, current Vice President of CICM, has written a piece for this issue of Critical Eye.

New Pharmacist members

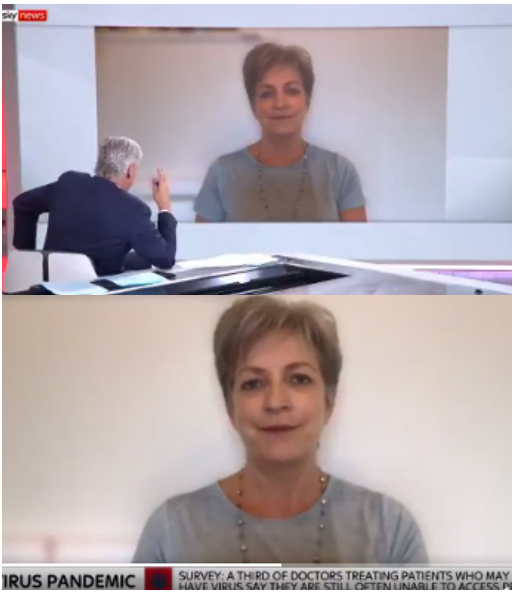
The success of our ACCP programme has not gone unnoticed and amidst the chaos we opened up a membership category for our pharmacist colleagues. Although this was being discussed pre COVID-19, the degree of collaboration between FICM and critical care pharmacists nationally during the first surge highlighted the importance of this development. I would like to offer a warm welcome to our critical care pharmacists and look forward to our new venture together.

Brave new world

I think 2020 will be our 'annus horribilis' so we have decided to have our birthday celebrations in 2021. We have been able to continue with some of our plans, such as Critical Aims and the Tim Evans essay prize, albeit on a slightly different timeline. Some, such as our annual meeting and the ACCP conference, were postponed and exams were cancelled. However this presented new opportunities to focus our podcasts and blogs on COVID-19 relevant topics, and to embrace digital technology in the form of the FFICM digital prep course and delivery of the FFICM SOE and OSCE exam. Examiners have been busy behind the scenes developing resources that can be used for a digitally delivered exam, trialling a variety of platforms (before settling on Zoom as the one that best meets our current needs), and undergoing hours of training to ensure that the exam goes as smoothly as possible. A huge thanks to the RCoA Exams department for all their hard work, Vickie Robson as Chair of the FFICM exam, and also to the trainees who volunteered to sit a mock virtual exam! Their feedback reassures us that digital delivery will replicate the face to face experience.

And finally ...

I would like to make a confession. I was unable to work clinically during the first surge, having sustained an injury just prior to lockdown. My first feelings were of anger and frustration about being unable to put my years of experience to good use. Next came the guilt around not being there to work alongside, and support, my colleagues. I was unable to leave the house to exercise due to the injury and the sense of isolation was unbearable. Eventually there was an acceptance and, if I am to be my usual 'glass half full' self, the opportunity to inform the public in a way that, 12 months ago, I would not have relished was the silver lining. I really missed contact with the outside world, which is now a very different to the one I left in March. I can't begin to imagine what it was like for those self-isolating for health reasons but I do hope that you are managing to reintegrate into the workplace.



NEW FICM BOARD MEMBERS

Dr Sarah Clarke

Driving standards in training and education have been major career objectives for me since I began working as a full-time Consultant at the Royal Blackburn Hospital in 2003. I've been a Faculty Tutor, Regional Advisor, and now since 2019, am the Lead RA for the 4 devolved nations. I sit on the FICM Training, Assessment and Quality Committee, and have represented the Faculty at HEE, AoMRC and GMC meetings. I'm also a member of the Curriculum Working Party, rewriting the Curriculum in line with Shape of Training, and am CESR Lead in the project. In 2018 I was appointed a FFICM Examiner and I also co-organise the national ICM recruitment process.

I want to continue using my enthusiasm and experience to support the Faculty, to ensure our trainees and colleagues of today and the future work in a collaborative, sustainable, resourced, and safe environment. Our patients and families come first and require an Intensive Care Consultant-led, standards-driven framework of multi-disciplinary care. Supporting our specialty, improving our services and looking to the future is my aim.

Dr Dale Gardiner

I was born, raised and trained initially in Australia. G'day.

Since 2002 I have called the UK home and from 2005 have been a Consultant in Adult Intensive Care Medicine at Nottingham University Hospitals NHS Trust. My long-term medical passions have been ethics, teaching, the history and safe practice of the diagnosis of death, organ donation and blood gases!

Three things I am most proud of in my career would be: running my regional ICM teaching for ten years, starting the national donation simulation course (and keeping it free for trainees) and helping to found the posthumous Order of St John Award for Organ Donation which has been given to over 5,800 UK donors and their families.

Currently, I am the UK National Clinical Lead for Organ Donation for NHS Blood and Transplant and chair of Nottingham Hospital's Ethics Committee.

Reflecting on COVID-19 has given me a strong desire to take the experience and skills I have gained through my national role in organ donation and use them to the benefit of the wider intensive care community. That is why I am so delighted and humbled to have been appointed to the FICM Board.

C19 SPACE

COVID-19 Skills PrepAration CoursE

The last few weeks have seen the Faculty involved in an exciting and ambitious programme, aimed at upskilling and training non-Intensivist doctors, nurses and AHPs for a second and subsequent pandemic surges. Some of you will have already heard and even enrolled in the ESICM C-19 SPACE Programme, and we are delighted to announce endorsement of the project.

Following the first pandemic wave in Europe, the European Commission funded and tasked the European Society of Intensive Care Medicine (ESICM) to organise and coordinate an upskilling training programme in preparation for a second wave. This programme is to be made available to all 27 +1 EU member states (the UK is the '1') and the deadline for the whole project is the 31st December (not just for the UK). Hence this rapidly evolving project, commencing training within the next few weeks is free to all, and the target is to train 10,000 medics, nurses and AHPs who do not regularly work in Intensive Care Units. Obviously, many Trusts have evolved their own upskilling and training routines for staff; this is not intended to replace but to complement existing resources. Detailed information can be found here: **ESICM's C-19 SPACE COVID Preparation Course**, but in essence briefly the project is:

- Free for all trainees, HCPs. Aimed at new ICM docs/non-ICM docs, nurses & other AHPs
- Registration will be 2 fold:
  - Individual hospitals
  - Individual personnel
- Consists of an online/remote learning course including Podcasts (approximately 16 hrs), then an 8 hr face-to-face, locally delivered, 'virtual-reality'-assisted course. (VR goggles to be provided!)
- All training resources will be provided
- There will be a 'fast track' option on the e-learning module for those already with skills gained previously (assessed by pre-test)
- ESICM are fully supportive of local adaptation and interpretation of the F2F scenarios for regions/ countries: acknowledging varying protocols/ guidelines and health care provisions in place across the European 'footprint'
- Completion of the course will attract a certificate which will have Europe-wide acknowledgement and recognition

Following on from rapid discussions and collaboration we are keen to support ESICM with our endorsement of the programme, and foresee the immense beneficial effects of a unified and consistent approach to upskilling our staff, with skills and abilities which can be transferable across regions, borders and specialties . We would urge you to get involved, sign up your Trust and Unit, by visiting the website before the deadline of 31 October.

CLICK HERE TO SIGN UP BY 31 OCTOBER 2020

Some Trusts are already enrolled and are busy signing up staff. It is hoped that with the National bodies, HEE and NHSE we can have a coordinated upskilling of our health-care staff in the UK, in readiness for future surges, and life on our Intensive Care Units, whatever that may hold.

Stay safe, be prepared, and be up-skilled.

COLLEGE OF INTENSIVE CARE MEDICINE OF AUSTRALIA AND NEW ZEALAND

Dr Rob Bevan
Vice President, College of Intensive Care Medicine Australia and New Zealand

On behalf of the College of Intensive Care Medicine of Australia and New Zealand, we are delighted to be part of the development of '2020 Vision: Arms Around the World'. This is a collaboration between CICM and FICM for learning and wellbeing within ICM, building on our common goals of training and education, recognising and encouraging diversity, and striving for equity. The purpose of this piece is to introduce CICM and hopefully get you to take a moment to reflect on how we can learn from each other.

Who is CICM?

The College of Intensive Care Medicine (CICM) provides the standards for training, certification and continuing professional development of ICM specialists in Australia and New Zealand (ANZ). Graduates of our training programme obtain an FCICM,the qualification which enables vocational registration in ANZ to practice within our specialty of ICM.

Outside of ANZ, we have established accredited training sites in Hong Kong, Singapore, India and Ireland, and collaborate actively with our Pacific Island neighbours.

A College of ICM – how did that happen?

In 1972, the Board of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons (FARACS) initiated moves to form a 'section of intensive care' within the RACS. Subsequently, the same group initiated discussions on setting up a joint specialist advisory committee with the Royal Australasian College of Physicians (RACP). The following four years were taken up by unsuccessful attempts to agree on a single joint curriculum or diploma, so that by 1976, training could culminate either with a qualification from the FARACS as an 'Endorsement in Intensive Care', or as an FRACP awarded in ICM. In 1992, the FARACS became the Australian and New Zealand College of Anaesthesia (ANZCA), with the RACP ICM pathway continuing in parallel. The foundation in 2001 by the RACP and ANZCA of a Joint Faculty of Intensive Care Medicine (JFICM) finally produced a single structure and a unified pathway for general ICM training. This unified faculty subsequently formed a new stand-alone College in 2008, with the CICM formally established in 2010 — an international first for ICM.

How we train ICM Specialists?

CICM training has evolved into a minimum six year programme, commenced after at least 12 months of general hospital experience. Training includes 42 months of specific ICU time divided into three stages: six months of foundation training; 24 months of prospective core training (after passing the first-part exam); and the final 'transition year' (after passing the second-part exam). One year of anaesthesia and one year of medicine are also required; but these can be retrospectively accredited from prior experience. The medicine component requires six months of acute care (which can be A&E or retrieval), and six months including outpatient experience of patients with chronic conditions. Within the six year framework, ICM trainees require at least three months of rural hospital experience and six months of accredited paediatric exposure.

Trainees also complete a suite of prescribed online and group-learning packages, associated assessments and specific skill-based programs. We also require trainees to learn focused cardiac ultrasound, and submit a logbook of at least 30 assessed cases.

The CICM second-part examination has existed since 1979, initially in the form of the 'fellowship examination' conducted by the Section of Intensive Care of the FARACS. This may have been the first ICM examination in the world, and is pitched to assess performance at the level of a new ICM Specialist.

What's this 2020 Vision thing about?

So you'll notice that there are some differences between the 'system' in Australia, New Zealand and the UK. There are also many similarities: We are a proudly eclectic bunch in ANZ, and more than a few of our trainees and Fellows (myself included) were born, raised and trained in the United Kingdom. We have had a dialogue with the UK Faculty for a few years, however it has become increasingly evident that as our specialty has developed, we should collaborate and learn together.... and that was before anyone had heard of COVID!

So we strongly agreed that as we each celebrate our 10th Year, now is the time for us to wrap our arms around the world, learn together, and support each other. We are delighted to work with FICM to share a '2020-Vision';to develop opportunities, promote wellbeing and equity, and advocate for our patients, trainees and specialists in those many areas of commonality, whilst learning lessons from where we each took different paths. This should be invaluable as we negotiate the uncertainties ahead.

We look forward to being closer.

FICM Patient Information Webpages

The FICM has launched a new patient area of the website. Within the pages you will find information on the patient journey through intensive care, along with Frequently Asked Questions and informational videos.

The webpages were developed by a working group which included patient representatives and clinicians.
We encourage you to share this useful resource with your colleagues, patients and their relatives.

https://www.ficm.ac.uk/patients

vCreate: a new communication tool during COVID-19 in Adult Critical Care in Scotland

Dr Helen Jordan
ST6 ICM Trainee, South East Scotland

Dr Sheila Rogers
Senior Lecturer, University of Edinburgh & Hon. Nurse Consultant, NHS Lothian

Significant restrictions on hospital visiting have impacted hugely upon the way we interact with patients and families. The absence of face-to-face communication has heightened anxiety and distress for everyone involved. Many families have struggled to understand the severity of their relatives' condition and what treatments have been offered. End of Life discussions have been particularly difficult since families have had no visual cues to complement verbal updates, and have limited comprehension of their relative's negative trajectory.

Scottish adult critical care units were offered a new method of virtual communication, vCreate, to bridge this gap. This has been a huge success, but not without challenges around implementation. It has raised many questions about the application of video communication in general and opened up possibilities to study the potential benefits and risks for patients, family members and healthcare staff.

In the early stages of the pandemic the Scottish Government issued guidance recommending the use of video communication whilst family visiting was restricted. NHS Scotland chose Near Me as their preferred live video consultation tool, as this was already in use in general practice and for remote clinics. The Scottish Government also funded an additional online application, vCreate, that could provide asynchronous communication for use in adult and paediatric ICUs. Developed in Glasgow Royal Hospital for Sick Children in 2017 by Dr Neil Patel, a Neonatal ICU Consultant, vCreate was promptly rolled out to other paediatric intensive care units.

vCreate is a secure online application used to send photos and video clips of patients and staff to family members. One major advantage over live video calls is the ability to capture events when they happen and later observe and approve content before sending to families. Consequently, families can be prepared in advance as to the content of the video. Clips and photos can be stored allowing them to be viewed by either the family or patient at a later date. These visual updates are intended to complement regular phone and live video medical and nursing updates.

Standardised training and information governance was rapidly developed and approved by NHS Scotland and each Health Board. A Scotland wide network was created to help support units using this new technology. The initial phase of implementation and staff training relied on members of the critical care team, staff appointed to non-clinical roles during the pandemic or redeployed from other areas. Rapid implementation and adoption of an entirely new method of communication during the COVID-19 pandemic was not without difficulty. Particular challenges encountered included:

- Implementing an application designed for paediatrics into an adult environment. This required multiple adaptations to be made.
- Significant restrictions on staff entering COVID-19 areas to provide training
- Restrictions on large group teaching
- New clinical protocols and procedures resulting in significant changes to all areas of practice
- Exceptional workload and demands on staff, limiting time dedicated to this new system

- Concern relating to images of ventilated and sedated patients and issues around consent

Despite these challenges the critical care teams across Scotland embraced vCreate and made it a huge success. vCreate went live in Glasgow QEUH ICU on 28th March and by mid-July it was being used by 16 units, had registered 315 families, taken 944 videos and 349 photos.

This virtual connection between families and the critical care units has enabled them to be far more involved in the patient's ICU journey. Most of the families receive an update every few days which often consists of a nursing or medical update, an orientation to the monitors or machines by the bed space, and the opportunity to 'see' the patient. Additional video clips and photos will depend on the family wishes and clinical status of the patient. We have used vCreate to send video clips of positive milestones e.g. the first time talking with a speaking valve, first time sitting upright in a chair, waving and even the first taste of ice cream after prolonged ventilation! This video content has provided a powerful source of solace to families and a great sense of achievement for our patients. Our preliminary feedback from patients' families has shown that it has reduced anxiety and they have found receiving photos and videos both reassuring and calming.

Whilst we have anecdotal evidence of the success of this method of communication, we are keen to conduct research to evaluate both staff and patient/family experiences. We anticipate that those family members who have engaged with vCreate will benefit psychologically from its use, although there is a small but real risk of negative experiences and traumatisation. Similarly, we have no knowledge of the short- or longer-term impacts on patients should they later view these videos with their family. Whilst healthcare staff appear to find this mode of communication acceptable and feasible, this also warrants further assessment. A team from NHS Lothian, the University of Edinburgh and the University of Hertfordshire have recently been awarded a grant by the British Academy to study some of these issues. We now look forward to exploring how vCreate can be used to support family and patient communication within critical care during the remainder of the pandemic and post-pandemic.

We would like to thank the whole vCreate team for contributing to this article.

Critical Care Advanced Communication Course

Dr Chris Booth & Dr Tom Wright

Intensive Care Medicine Consultants
Salford Royal Care Organisation

Intensive Care Medicine requires frequent communication most obviously in discussions with relatives. We also use our skills directly with patients, with the team we work in and with visiting specialists. Some of this will be or seem routine, but much of it is complex and challenging. We deal with emotive, primed individuals (both relatives and specialists) in clinical situations where the stakes are high, frequently quite literally life or death. Within this environment we are expected to deliver clear and focused communication of concepts that can be difficult for non-clinicians to understand (neurological death testing is one such example).

Given this background, it is clear why communication skills are a part of the curriculum for a CCT in ICM. The process by which these skills are acquired is variable and ad hoc, both in quality and quantity. It is predominately delivered in the clinical environment either through observation of others or unsupervised personal experience (learning by doing). This has merits but provides little opportunity for feedback, is unsafe for testing or trialling different methods or styles of communication and has little space for peer reflection and shared experience.

Communication skills courses have been a feature of medical training for some years now, either as part of an undergraduate curriculum or as post-graduate sessions. Some of the content of these courses is relevant to ICM practice, for example breaking bad news, however they are not bespoke and rarely feature the more unusual or complex challenges that present to the ICM clinician.

In 2017 we recognised that there was an opportunity to develop a training course to meet the specific needs of ICM. This led to the (slow) birth of the Advanced Critical Care Comms course based at Salford.

Course Development

The reason for embarking on this was our own experience of communication as practising intensivists; our aim was to provide a wide experience of the more challenging situations that we have faced, ensuring that we covered the repeated aspects of communication that are the bedrock of our specialty.

We have been involved in simulation courses, including the excellent National Deceased Donation Course run by NHSBT, over the past few years and sought to draw on the experience gained from these settings. High fidelity simulation of communication is predominantly dependent on providing a realistic and targeted scenario, believable characters and high quality actors capable of giving authentic responses to the candidates. Designing our scenarios was relatively straightforward and we drew themes from many years of faculty experience. It was more challenging to distil a single aim from each scenario as most communication in practice has multiple arms.

From the outset we decided to avoid any form of didactic teaching. Our belief is that our candidates usually have a good grounding in communication skills, developed from their personal experience. Whilst we do discuss communication theory during the course, we do not espouse any particular one model, preferring to draw on the combined experience of faculty and candidates to develop skills.

Not all communication is with relatives

If you ask any ICM clinician to describe a difficult communication scenario they will invariably describe a conflict with relatives. In seeking to provide a more rounded experience, we recognised that some of the

more challenging situations that we face are with colleagues. Providing simulated experience of these was a particular difficulty for our course development. What we find difficult during interactions carries a degree of individual variability; we did not want to create a stereotypical 'difficult' colleague on which to base our session. Instead we decided to follow a workshop model for this part of the day, where candidates bring a scenario they have found challenging with them. Our acting team are briefed on the scenario by the candidate and then discuss the behaviours and language used by the individual who was encountered, with faculty providing support for clinical aspects of the encounter. The candidate can then experience the situation in a simulated environment and can try different approaches to develop their skill in handling them. Peers contribute with suggestions and can also join the scenario to demonstrate how they might handle it.

Getting it right by getting it wrong

The other aspect of communication simulation that we consider beneficial is the development that can be derived from 'getting it wrong' and equally from the ability to try something new. Our experience from other courses (and from being candidates ourselves in the past) is that individuals rarely wish to do either of these things so to provide this opportunity in a safe manner we have developed one session in which the faculty take the hot seat and are thrown into the clinical scenario. Rather than try and model our faculty interpretation of best practice, we allow the candidates to set the scenario up and then direct how the faculty approach it. This can lead to some interesting outcomes, some entirely predictable and others that surprise even us. The opportunity to experience "I've always wondered what would happen if I…" can be quite powerful.

COVID-19

It is not possible to describe anything in ICM at the moment without reference to COVID-19. It has had a tangible impact on our course as we were due to run one in the week before lockdown. In common with many other educators we took the decision to cancel the course to minimise disruption to clinical activity and risk to our candidates and faculty. We are now faced with the challenge of restarting in a new world of social distancing and restrictions. This is particularly difficult for a course based on communication simulation where fidelity has traditionally been dependent on close physical proximity and contact (particularly between actors). We have developed solutions to this including modification of the scenarios to reflect real-world COVID-19 experience of social distancing in relative interviews. Many of us will have had a rapid induction into the use of video conferencing to facilitate discussion with relatives and we are introducing scenarios into our course to reflect this. This is an emerging area for ICM; our personal experience suggests it is better for relatives than telephone discussion, but there is a learning curve and skills which we can develop to maximise its usefulness.

Delivering the course

From the acorn of an idea to actually running our first course took approximately two years, with various work and non-work interventions delaying us. We have now run two courses and have received fantastic feedback from those who have come to take part. The nature of the course means that it is demanding on faculty, time and finance and in order to provide a high-quality experience for our candidates, we have to restrict the numbers that can come on each day. It is our belief that every ICM trainee should have the opportunity to experience communication skills training as it is such a fundamental part of our job. The course we have developed is easily transferrable and modifiable, if you've ever thought of developing something like this we would be delighted to share our experience; we usually learn as much from others as we can teach ourselves.

The above course is shared for information only and is not endorsed by the FICM.

Investigating and Innovating COVID-19 Critical Illness Rehabilitation

Dr Todd Leckie, Dr Alex Hunter & Dr Luke Hodgson
Critical Care, Worthing Hospital

Recovery from severe COVID-19 has presented novel challenges to critical care rehabilitation services, both due to the unknown nature of the disease course and the requirement to adapt services within the context of social distancing and enhanced infection control precautions. In particular, the objectives of meeting the NICE quality standards regarding the development of discharge rehabilitation goals, and providing follow up at 2-3 months post-discharge, have been identified as requiring innovative and collaborative solutions.

To meet the challenge of understanding and supporting COVID-19 recovery the Critical Care Department at Worthing Hospital and the University of Brighton, conceived COVID-OR, a 12-month multi-centre observational study that incorporates the use of Fitbit smartwatches to monitor activity levels of critical care discharged COVID-19 patients. The Fitbit watches use accelerometer and heart rate sensors to monitor and stratify activity intensity. Allowing the patients and researchers to measure periods of exercise activity and also track changes in overall day to day activity.

Incorporated within COVID-OR is a further feasibility project whereby a virtual multidisciplinary team meeting has been established to specifically review the Fitbit data for each former Worthing patient. (The MDT occurs via video conference and consists of respiratory and critical care physiotherapists, respiratory medicine consultants, critical care junior doctors, GPs with an interest in sports and exercise medicine and exercise physiologists. Patient data is evaluated and assessed for rehabilitation activity based on patient goals, demographics, previous physical activity, clinical and social information and progressive nature of step count and activity intensity since discharge. Simple motivational information is fed back to patients that could be categorised by the following: reducing sedentary time, increasing steps to a specific progressive goal, more consistency of day to day activity and more time in higher intensity activity zones. This method represents a holistic consideration of the patients' activity needs and provides an appropriately simplified instructional use of the watch activity data for the patients to progressively develop activity post-discharge.

In addition to quantifying physical recovery, COVID-OR has sought to understand the psychological experience of COVID-19 during the acute and recovery phases, and the interplay between this experience and recovery. Interviews have been conducted with health professionals on the front-line in four hospitals, as well as COVID-19 critical care patients and their relatives.

COVID-OR will contribute a valuable insight into both the physical and psychological aspects of COVID-19 recovery and rehabilitation, collating vital information that will shape the care provided for current and future patients. Already it has highlighted the potential of ambulatory wearable technology to augment the patient journey during critical care rehabilitation and the benefit of utilising an MDT approach when creating systems to harness new technology within a clinical setting. For more information on our work please contact lead investigator Dr Luke Hodgson (luke.hodgson2@nhs.net). We would like to thank Dr Ben Hardy, Dr Ana Ana-Carolina Gonçalves, Dr Dan Fitzpatrick and Dr Alan Richardson for their contributions to this article.

Self-isolating Virtual Education Project (SAVEd ICM)

Dr Emma Tant
ST6 ICM Trainee, North West

Coronavirus has affected the ICM community significantly; not only have we seen increased numbers of patients, difficult working conditions and changes to rotas, but study leave, teaching, courses and exams have also been cancelled. At the beginning of lockdown, I found myself needing to self-isolate. Whilst working from home, I helped to develop SAVEd ICM (Self-isolating Virtual Education) Project.

During the COVID-19 pandemic, it was recognised that ICM trainee education was going to suffer. The North West anaesthetists had just started a project to create an alternative to their teaching program, and we decided to do the same. After advertising the project through trainee emails and the trainee WhatsApp group, there ended up being a small group of ICM trainees self-isolating, and some who, whilst still working, offered to help out with some presentations.

We started by asking those organising the next few scheduled teaching days to send programmes and any pre-made presentations to a dedicated email account and associated Google Drive account.By using these and by looking at the curriculum, we designed presentations to cover the topics. We distributed the topics between ourselves, and created the presentations, focusing on one teaching day theme at a time.

We added audio, and both the videos and slides were published on our local ICM and anaesthetic website (www.mmacc.co.uk) alongside the anaesthetic presentations. Each presentation was targeted at pre-FFICM trainees and lasted 20-30 minutes. With study leave cancelled, the shorter presentations allowed for trainees to continue their learning without needing to spend hours at a time on it. A feedback form link was put next to each presentation, which allowed feedback to be given to the presenter and also generated a certificate for the learner with an associated 0.5 CPD points, as agreed by the deanery.

Beyond the main self-isolating team, anyone needing to self-isolate for 14 days, and those who had pre-made presentations on our given topics were asked to contribute presentations. They also receive feedback on their presentations. It is now looking unlikely that traditional teaching will resume for the next few months, so the team are in the process of creating teaching days, via Zoom, in collaboration with the host organisers.

The aim of SAVEd is not to replace traditional teaching days; we are unable to do simulations and there is a real advantage to the social aspects of a teaching day, but hopefully SAVEd will bridge the gap in the meantime and provide an alternative for those who can't attend that particular day. These teaching days will be recorded and will be available 'on demand'. In conjunction with e-learning for health modules, we aim to cover the majority of the curriculum.

So far, the feedback has been positive. There is a desire for additional help in exam practice, and we are currently looking at how to achieve this from a practical point of view. As times change, so will we, and we intend to get all of our teaching over a two year cycle completed. COVID-19 has changed how many of us work and live, and by adapting to our new normal way of living, new opportunities arise. Some things may go back to how they were, but we aim for the SAVEd ICM project to continue and to run in conjunction with traditional teaching.

We need to talk about Human Factors ...

Dr Will Peat
Consultant Anaesthetics and Intensive Care Harrogate Hospital
Foundation Year 2 Training Programme Director
Simulation and Human Factors Lead

In 2005, Elaine Bromiley died following unexpected complications related to airway management during a routine elective procedure. As a result of this tragedy, her husband Martin founded the Clinical Human Factors Group (CHFG). The aim of the group was to raise awareness and promote human factors in healthcare. 'Human factors' is now so prolific that it would be unusual to undertake any clinical investigation or perform simulation training without the words "this is human factors" being used. But what do we really mean when we talk about human factors and ergonomics (HFE)? Though HFE is now commonly considered, the concept is frequently misunderstood and its potential impact underestimated.

If you limit the application of human factors to team working, communication and situational awareness, then you risk limiting your focus to only a small part of the story. More importantly you are only unlocking a small part of the potential benefit.

As the Human Factors Lead within my trust, I have become an associate member of the Chartered Institute of Ergonomics and Human Factors (CIEHF); a move I would recommend to anyone who has an interest in HFE. In doing so I have gained access to trained ergonomists (human factors specialists) who are working nationally within the healthcare setting. It has also offered me a far greater insight into what human factors *really* is, has helped clarify what it isn't, and has highlighted its unique potential to improve safety in critical care.

As with many things in today's world, we must look to history to understand how concepts have evolved in their application. It may feel like a cliché but it's important to comprehend how HFE developed in the field of aviation to appreciate the journey that healthcare has taken.

In the Second World War the United States Air Force lost many hundreds of planes in accidents wrongly deemed to be 'pilot error'. It took some of the forerunners of human factors engineering, and not an aeroplane manufacturer or pilots, to notice that a design error in the cockpit was causing the accidents. With a redesign of the cockpit, 'pilot error' reduced dramatically. In the post war period, with further evaluation of cockpit design by HFE experts and the improved engineering of planes, we saw more and more errors being 'designed' out.

It wasn't until the 1970s when the airline industry started to realise it had a new emergent systems problem. The industry began to recognise their newest safety issue was the interactions of the crew. Recognition that these factors could be involved in accidents led to the inception of Crew Resource Management (CRM). CRM focuses on interpersonal communication between crew members, leadership and decision making, many of the topics people associate with HFE in healthcare. It is unsurprising therefore, that when aviation experts started delivering training in the healthcare settings they began with CRM, recognized as the most pertinent issues seen in their field.

This has led to the term HFE being used somewhat interchangeably with CRM. In reality, HFE is a much broader concept, with CRM beneath its umbrella. Where aviation had considered environmental HFE design, healthcare still needs to fully evaluate many of these aspects.

our own 'cockpit'. We will still maintain the threat of poorly designed equipment, packaging and workplaces. We remain wedded to inadequately designed guidelines and policies and work with inefficient staffing and roster design. In healthcare, we need to first use HFE to unpick and understand these issues more deeply. Only when we have considered design solutions properly, can we meaningfully attempt the Sisyphean task of educating all staff in CRM.

In early 2020, with the perceived threat of the COVID-19 pandemic, the government called on the manufacturing industry to help produce ventilators. There was real concern from front line critical care staff that these ventilators would not be 'fit for purpose' by our staff and for our patients. Step forward the CIEHF who rapidly put together 'Human Factors in the Design and Operation of Ventilators for Covid-19', a collaborative project between critical care clinicians and HFE experts. This document gave pointers to potential designers, with consideration given to key topics including the user, the user interface, the environment in which ventilators are used, the risks of using a new ventilator and the specific training requirements needed. Thankfully, this guidance was never required.

On the face of it, it would seem, all you need is a 'common sense' approach when designing something mechanical such as ventilator, but unless you use an HFE approach you will not consider all the vital elements. You only need to look at frustrations with using hospital IT systems, compared to the off the shelf usability of smart phone apps, to appreciate that common sense is notoriously uncommon unless you use HFE principles to underpin system design.

A simple practical way to start to use human factors in your critical care unit is to perhaps consider some of the guidance that the CIEHF and CHFG have produced most recently.

I challenge you to take a look at some of the standard operating procedures and checklists you already have in use; 'Guidance to help design effective and usable work procedures for health and social care teams'. It will show you simple but effective ways in which you can start to incorporate human-centred design within guidelines. These may well have proliferated during the recent COVID-19 pandemic. The second document, 'Bedside Guide to Routine Tracheostomy Care', which is endorsed by the Intensive Care Society and Faculty of Intensive Care Medicine, gives guidance to those routinely caring for tracheostomy patients. It shows how a human centred care pathway can be produced for a specific patient group. Tracheostomy care is associated with significant morbidity and mortality within critical care.

Perhaps the final words should go to the CHFG where this all started. Human Factors are organisational, individual, environmental, and job characteristics that influence behaviour in ways that can impact safety. We need to interrogate and understand these characteristics to keep patients and staff safe.

COVID-19: The role of the Ophthalmologist in the ICU

Dr Minak Bhalla[1], Mr Rohit Jolly[2] & Mr Saurabh Jain[2]

1. Specialist Trainee in Ophthalmology, Royal Free Foundation Trust Hospital
2. Consultant Opthalmologist, Royal Free Foundation Trust Hospital

The COVID-19 pandemic has had a devastating impact on patient lives. Current data reports that patients with co-morbidities (older age, chronic respiratory disease, cardiovascular disease, diabetes mellitus, obesity and immunocompromised states) are at higher risk of COVID-19 associated complications, Intensive Care Unit (ICU) admissions and fatalities. The strain on the healthcare system in the UK has led to drastic restructuring and reallocation of resources to help cope with the growing demand.

To better manage the pandemic, elective surgery and outpatient services were cancelled to help increase capacity. Doctors and nurses within sub-specialities like Ophthalmology have been supporting medical and critical care services while continuing to see and treat Ophthalmic emergencies. The demand for internal reviews has increased, in particular from ICU especially for proned patients. ARDS patients are regularly proned to aid their respiratory rehabilitation whilst they are ventilated, and this positional change helps reduce pleural pressure and restore oxygenation to lung segments). Furthermore, patients are unable to communicate changes in their vision or new onset of pain that may suggest evolving pathologies. This poses additional difficulties for ICU staff who are already inundated to recognise and appropriately escalate for specialist input. This article highlights common ophthalmic conditions and their management during this challenging period.

Lagophthalmos and Exposure Keratopathy

A common ophthalmic complication from ventilated patients is lagophthalmos. Intubated patients are sedated and paralysed which prevents the orbicularis oculi muscle from closing the lid. This impairment of eye closure together with loss of the Bells reflex, results in corneal surface exposure and subsequent drying can lead to corneal epithelium breakdown. Intervention for lagophthalmos can be determined by the extent of exposed cornea and regular lubrication and horizontal taping of the eye lid would be the most appropriate initial course of action). This can be easily taught to ICU staff and in the event of more significant lagophthalmos, medical therapy to induce a ptosis with botulinum toxin injections or a surgical tarsorrhaphy can be considered.

Conjunctivitis and Microbial Keratitis

ICU patients are exposed to numerous sources of infections, whether it be from commensal bacteria, respiratory aerosols or contact from suction catheters. Commonly grown bacteria in ICU patients have been Staphylococcus Epidermis and Pseudomonas Aeruginosa. Attending staff must be vigilant in noting conjunctival injection, mucopurulent discharge and corneal opacification. Conjunctivitis requires a swab for microbial culture, regular ocular cleaning and topical antibiotics as per local microbiology guidelines.

Microbial keratitis will need to be reviewed by the Ophthalmologist and the size of the infiltrate along with the anterior chamber activity accurately recorded. Microbial keratitis will need to be treated with an intensive course of hourly 4th generation fluoroquinolone antibiotics, or in accordance to local microbiology guidelines, for 48 hours at which point the patient should be reassessed.

Chemosis, proptosis and orbital congestion

COVID-19 patients are at risk of orbital congestion due to hydrostatic pressure from the gravitational changes during proning, positive-pressure from the

ventilators and the increased capillary leakage from their pro-inflammatory states. The majority of patients will find their chemosis settles with conservative management once the patient is supine however, the Ophthalmologist will have to be aware of the rare orbital compartment syndrome. This irreversible sight loss complication has previously been reported in spinal surgery patients who are placed in the prone position for a prolonged periods of time. Assessment of the eye is vital in determining the need for urgent intervention and this involves digital palpation of the globe to assess for a tense orbit and measuring intraocular pressure if possible. A relative afferent pupillary defect (RAPD) with a notable proptosis and tense orbit will be suggestive of compressive optic neuropathy where an urgent bedside cantholysis may be indicated.

Pupillary abnormalities

Relative afferent pupillary defects (RAPD) indicate a defect in the retinal ganglion nerves pathway to the optic nerve or the subsequent optic nerve pathway towards the midbrain. This can be assessed by the swinging light test, where the impacted eye fails to constrict upon exposure to the torch light. The commonest cause of RAPD is due to optic nerve pathology from ischaemia, inflammation or compression. However, the Ophthalmologist should also examine the patient's retina for ischaemia, infection (CMV) or haemorrhagic causes. Although ophthalmic intervention for some of these conditions will be difficult in the ICU department, diagnostic confirmation could help with systemic treatment and visual prognosis.

COVID-19 patients are highly susceptible to coagulation disorders, with numerous cases of pulmonary emboli being reported. Pupillary abnormalities can be a presenting sign for retinal vascular occlusions or cavernous sinus thrombosis and identifying this can indicate further investigations and treatment.

Optic Neuropathy

The anterior and posterior portions of the optic nerve are supplied by the ciliary and plial arteries respectively. This network of short arteries can come under insult in critically unwell patients. ICU patients often have evidence of global hypoperfusion, or a systemic inflammatory response syndrome, are on high ventilatory support or required cardiopulmonary resuscitation and as a consequence have a higher incidence of anterior ischaemic optic neuropathy. Since most COVID-19 patients are transferred to ICU for ventilation and inotropic support, a combination of these factors along with regular proning increases the likelihood of optic nerve hypoperfusion and subsequent neuropathy. Referral to Ophthalmology should considered for a dilated fundal exam in any patient who may show signs of RAPD.

Endophthalmitis

Endogenous endophthalmitis remains a risk for COVID-19 patients due to intravascular catheters, parenteral nutrition, dialysis, and the use of broad spectrum antibiotics. Candida albicans and bacterium like Pseudomonas impose the biggest risk to endogenous endophthalmitis. ICU staff may find it difficult to recognise this in sedated patients unless there is a notable hypopyon, thus a dilated fundal examination will be required once there is positive blood cultures and the patient will need to be initiated on systemic antifungals or antibacterial. Moreover, chorioretinal lesions with vitreous activity may warrant intravitreal antifungal or antibacterial treatment in accordance to local microbiology protocol. The lesions can be isolated or disseminated across the retina and the ophthalmologist will need to be aware that the view may not be clear due to an inflamed vitreous as well as poor ocular surface coupled with poor dilation of patients on opioids.

This article has highlighted the importance of a thorough ocular assessment in COVID-19 ICU patients. The majority of patients in ICU will be sedated and will be unable to communicate changes in vision. ICU staff will play an important role in maintaining good eye care while being vigilant in identifying patients with evolving signs for further assessment. The ophthalmologist will have to be alert and not miss an array of conditions that have been described due to the complex pathophysiology and developing understanding of COVID-19 as well as a demanding clinical environment. It is evident that the Ophthalmology team will play an important role in the management and rehabilitation of patients who have been in ICU due to COVID-19. If you would like a list of references to accompany this article, please contact the Faculty at contact@ficm.ac.uk.

Life Goes On. Even if it's not our own: Returning to work during COVID-19

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When you wake up in a ward that you used to work in, things feel very different. The key things that were on my mind seemed so simple, but more than important. Sleep, comfort, hunger and dignity.

As days turned into weeks and months, the 'normal' complex thoughts and feelings returned. Life wasn't a continuum but like a chaptered story. 'Return to work' being the title of the chapter that I was desperate to be able to read. As the months approached a year, I felt more than lucky to sense that I was on a path that led to somewhere where I would return to work. We all analyse ourselves, but we may not indulge in it or talk about it. Everyone on this planet is essentially a patient with their own physical and mental health.

My rehabilitation became a full-time job, and as the months passed, I wanted to turn the page onto being myself before I started my return to work. The complex and fundamentally vital 'work-life' balance needed focusing on, so I could self-equip myself. Just as I was able to start exploring my next chapter with vigour, COVID arrived. Isolation and then lockdown meant that once again, an unexpected chapter was starting. It honestly felt like it was just another phase of my recovery. This time though, it wasn't specific to me. Everyone's bubble was bursting at the same time. I had quickly realised that me going to intensive care as a patient, was worse for my loved ones than it was for me. This time, however, the new COVID chapter has an effect on literally everyone.

My return to the workplace hit me for six for a number of unanticipated reasons. I wasn't prepared for the warm emotion that I received from staff. These people excel at how they spend their time looking after others for a good reason. I also was hit hard by the feeling of being within touching distance of what I loved being a part of. Caring for others. The gravity of the previous year landed. As the dust settled, I became vividly aware of a new realm that everyone seemed to be living in.

Staff were at full tilt. They were working really hard and clearly feeling a huge responsibility and desire to do their jobs well. Everyone seemed to be maxing out their physical effort, mental effort or both. I arrived at a point in April when the cost of people working so hard was apparent. It was also clear that staff were becoming concerned or frustrated at the cost that their loved ones were paying.

It was around this time that I really started to recognise the strain on myself. I'm not prone to too much self-analysis. I'm not very good at it when I do and it's almost always in retrospect. I think it was different this time though, perhaps because of the shared nature of the stress.

I had a number of plans and goals for the year that I had been mapping out. This was going to be a good year after the stress of buying houses, passing exams and family illnesses in recent years. As things started to get cancelled or postponed in April then May I started to get

frustrated but then my plans for August and September started to get affected. Each new cancellation started to feel like a mini bereavement for the life I planned this year. Tumbling through Kubler-Ross I always landed on 'Bargaining' – "Okay, I won't do that thing but at least I've got this other thing to look forward to'. Until I simply ran out of things to look forward to.

No staff complained to me about the situation they were in. They all gave me the sound impression that they were people doing what they felt needed to be done. But it was coming at a cost. If the conversation about them wasn't on 'why', but rather about 'what next', most drew blanks. Burnout was raising its head in all directions.

One of the many silver linings that I've observed myself benefiting from in the last year, is what I've learnt from observing how I think. The conversion of feelings into thoughts and then maybe words is complicated. From day one I wanted to get better and I turned a spotlight onto myself to analyse why something was difficult or easy. Why was it different? How could I improve? Looking back, I wish that I had accepted that I just needed to wait, and it would all get easier. That's one of the perks though of having some types of injuries and being on a path of recovery. There's something to look forward to.

COVID-19 seems to be changing everything. Looking forward to something is one thing, but not knowing what the future is going to hold is a real thing. Doctors were working hard, but the old work/life parameters had suddenly changed and everything in their lives seemed to (normally) be evaluated and under a strain. I missed my job for what it was and I knew that I didn't care about the title. I could see that staff were also focusing on their job, their responsibilities and their desires. But they were keeping it simple. Making a meal, sitting outside, cycling their bike or swimming in the sea. They didn't talk about holidays, visits or nice meals they had eaten out. They all talked about simple things that clearly mattered to them. The key parameters of sleep, comfort, hunger and dignity had returned.

I got over my slightly petulant moment of self-pity. It really doesn't matter if I get to do another bike ride in the Alps or not this year. I'm healthy, and my great fear of having to treat a close colleague or loved one has yet to transpire. I needed an alternative project that didn't involve anything in the hospital or goals that are subject to cancellation or postponement. With more focus on staying at home we got a dog. A dog that is a lot of hard work if his basics of sleep, comfort, hunger and dignity are not seen to.

Everyone is a patient. Self-analysis has taught me that I've always had flaws, but I also have accepted that it's normal to be different and sadly not perfect. It is normal to have periods of time where you feel unhappy. Accepting that mantra is possibly an important step towards improving one's mood. It's okay to feel fed up, it's just important that you recognise that you are, and then try and help yourself. The pandemic has burst everyone's bubble for different reasons, but if we're lucky enough to be alive, then we all need to think about our specific self-rehabilitation. Care for people, including yourself.

SMALLER AND SPECIALIST UNITS ADVISORY GROUP

Dr Chris Thorpe

Chair: Smaller and Specialist Units Advisory Group

Where can you train effectively in intensive care medicine? The answer depends on two factors: exposure to clinical material, and the ethos of the unit when it comes to training and support. One of the difficulties in recruiting to some intensive care units comes when trainees have had no exposure to that particular unit, but in addition it may be that the trainee has had no exposure to any units of that type. It would then become difficult to fully grasp the positives and negatives of working in that unit.

We have recently increased the number of training posts in ICM and this is an ideal opportunity to open up the training scheme to include some time in small units. This will allow our future workforce to experience the work life balance in different types of hospitals, and potentially to increase the number of applicants into smaller units. This is vitally important; we continually aim to have ICM consultant posts filled by trainees who have a CCT in ICM, but if our trainees do not apply for a post then the laws of supply and demand prevail as the work still needs to be done.

The clinical material in smaller units is of course less, however the number of trainees can be vastly reduced and therefore the amount of experience gained for an individual can be high. In addition, the trainee will become known to the smaller team very quickly, who are able to have confidence in the trainee from an early stage, leading to potentially more responsibility being taken on. There is also less competition for practical procedures so a trainee can gain great experience in a small unit when combined with larger units as part of the programme.

The training ethos is very important. In today's climate there needs to be a very clear approach to training by the educational and clinical supervisors. If trainees do have an attachment to a smaller unit, it is important that there is a clear understanding of the curriculum requirements and that the educational supervision is robust. This may require collaboration between the unit and regional larger centres so that the appropriate support is in place. Attendance at the Specialist Training Committee by the local trainer would be an important factor in ensuring a good standard of educational supervision. The FICM have recently released guidance encouraging the incorporation of smaller units into training programmes. Widening the footprint of training is not only good for the trainee, who experiences different system approaches to care of the critically ill, but also helps the unit where education and training adds another dimension to the work of permanent staff.

As we all know too well, administration of training within our units involves a huge amount of contact with the wider training world. Everything from curricula requirements, training surveys and organising teaching through to keeping your educational standards up to speed for appraisal keeps you busy. The unit would be incorporated into the wider network of training units, and be involved in the regional teaching schedule. This incorporation into the education setup helps against isolation and keeps all staff fresh. Trainees also bring ideas from previous attachments, and act like intracellular messengers communicating little packets of information between units.

'Widening the training programme in ICM: New training posts for 2020' can be found in the Smaller and Specialist Units section of the FICM website.

GETTING IT RIGHT FIRST TIME

Dr Anna Batchelor
GIRFT ICM Lead

What a roller coaster ride the last few months have been! Caroline, a GIRFT project manager, and I travelled to just under half of the units in England before the pandemic struck and halted all visiting. I would like to thank everyone who welcomed us to their units for being so open, honest, engaged and interested in how their unit compared to others. It was an enormous pleasure to meet so many people and to really understand the issues faced in so many units. I don't know if I'll be able to do anymore visiting as clearly infection control and travel are a major issue. We could try virtual visits now we are all so good at Zoom and Teams etc, but one of the real benefits of being in a room with everyone is being able to feel the vibe and usually get everyone talking; I would miss so much without that. And of course the chance to sample every Costa coffee shop in England and stay in some very dodgy hotels!

We have written our draft report, consulted with stakeholders and we are hoping to get the final version ready to publish this autumn. You won't be too surprised at some of the highlights; there is huge variability in access to Critical Care, patients do not get the same deal in every hospital and unit. Resource of all kinds is a problem in many units, this includes beds and staff at every level. Some parts of the country, have difficulty recruiting to all specialties, which can lead to a very unstable workforce and make substantive recruitment even more difficult. Allied health professionals are often only available five days a week or in the case of occupational therapy, psychology, and speech and language therapy in some cases not at all. Access to follow up and rehabilitation services are also very patchy.

This is not Getting It Right First Time!

Whilst I would never recommend a pandemic to anyone, it has served to highlight the problems critical care has been having for many years and made them much more difficult to ignore when everyone in the country now knows what a ventilator does and how difficult they are to find. This does mean it is an opportune moment to publish our report and hopefully effect some changes. Our recommendations include:

- Reviewing and increasing bed numbers including Level 2 & 3 and Enhanced Care beds
- Developing national default patient pathways for high risk major surgery and high risk patients using Enhanced and High Dependency care appropriately
- Develop and fund adult transfer services
- Increased use of Advance Care Planning
- Develop and fund rehabilitation services post critical care
- Meet GPICS staffing levels
- Support training of more ACCPs
- Research effects of altered staffing patterns used during pandemic surge and learn from the good and bad points
- Develop datasets to monitor patient recovery and rehabilitation
- And much more

As they say in the North East "shy bairns get nowt". The pandemic money tree may now be losing its leaves, but it's clear we needed to invest in our critical services before and the need is now greater to safely manage a second surge over the coming winter.

I wasn't sure what I was getting myself into when I agreed to take on the GIRFT project; what I can say now is it has been an honour and a privilege. I couldn't have done it without the assistance of David Harrison and Kathy Rowan at ICNARC, the support of the Faculty and ICS, the wise council of the Critical Care Reference Group, the fabulous data people in GIRFT, and you.

LIFE AFTER CRITICAL ILLNESS

Dr Carl Waldmann

Chair: Life After Critical Illness Working Party

Life After Critical Illness (LACI) was deemed to be an important work stream for the Faculty since the development of a critical illness aftercare services was recommended by Critical Futures published in 2017. The aims of the project are to:

- present a UK wide survey of current practice
- provide an outline of existing service models
- examples of business cases
- make recommendations about the future need for resources for these programmes
- outline future research proposals to evaluate existing services and outcomes.

Provisional guidance has been published to support the pandemic and provide a national framework for future Critical Illness Recovery Services. The Faculty's Life After Critical Illness Working Party (LACIWP), incorporating multiple organisations to ensure close collaboration with the MDT, will now continue work on its full guidance document, taking into account any additional learning from the pandemic.

Until recently there was little in the literature about what happened to survivors of critical illness after they left hospital. In 2009, NICE provided CG83 Rehabilitation after Critical Illness; unfortunately, this achieved limited traction. In 2015, the Scottish Intensive Care Society Quality Improvement Group published guidance, making critical care rehabilitation one of its Quality Indicators. In 2017, NICE published its Quality Standard (NICE QS 158), and since then there has been more of a concerted effort for all critical care services nationally to provide rehabilitation and follow up. Funding remains a problem; to date this has been primarily achieved by local ICUs submitting a business case to commissioners. Unfortunately, these often fail due to a lack of supportive clinical evidence and a challenging financial climate in the NHS.

It is clear that recovery from critical illness is complex. Since 2010, the term Post Intensive Care Syndrome (PICS) has been increasingly utilised to describe the complex long-term sequelae of critical illness. PICS has three key patient-centred domains at its core that can individually be impacted; the physical, the cognitive and the psychological domains, the latter affecting both patient and family. The question of who should provide intensive care aftercare services has stimulated debate about whether it should be intensivist led or otherwise.

The argument for these services being provided by the intensive care staff is hard to contest, with numerous benefits for patients as well as for staff. These include feedback from patients and caregiver (family) to ICU staff to influence changes in practice within the ICU, the enabling of revalidation for healthcare professionals and provision of a narrative of individual patients' outcomes for staff, which can improve morale.

The ICU multidisciplinary team are expertly placed to understand, interpret and plan the recovery phase of the patients' illness and signpost them appropriately to other hospital or community-based specialties. The patient feedback for these critical illness recovery clinics consistently highlights the benefit of hearing a narrative account of their ICU stay along with the review and normalisation of their ICU delirium experience. Some patients will have very severe on-going disability following discharge requiring specialist inpatient or community-based rehabilitation. Others require a variety of community-based rehabilitation/support services including cardiopulmonary rehabilitation, sports and exercise medicine, psychological, vocational support etc. All of these services need to be working in coordinated networks to optimise the care of patients who have been critically ill.

BETTER TOGETHER: COLLABORATIVE WORKING BETWEEN EMERGENCY AND CRITICAL CARE

Ms Anna Ripley
FICM Education & Standards Manager

Post lockdown, work has picked up again on the framework and we are just about to launch the document for open consultation. We have already consulted a range of stakeholders including patients, Royal College of Anaesthetists, Society of Acute Medicine and the Resuscitation Council UK, but now is your chance to let us know what you think.

This document aims to provide practical outcomes to foster closer working relationships and to achieve consistency in clinical care for critically ill adult patients in the resuscitation area in emergency departments across the UK.

Adverse effects on both patients and staff continue as numbers of people presenting at the front door rises incessantly. The evidence for this mounts as patient flow through the hospital fails and substantially contributes to departmental crowding. This document is part of the effort to mitigate against such pressures. FICM and the RCEM have united to define a strategic direction for the care of the sick patient in the resuscitation area. The aim of this document is to improve patient outcomes through the promotion and maintenance of collaborative working between emergency care and critical care.

FICM SEPSIS UPDATE

Ms Anna Ripley
FICM Education & Standards Manager

We are working on behalf of the Academy of Medical Royal Colleges on a guidance document to reduce unnecessary antibiotics and create some national uniformity, when diagnosing Sepsis. A multi-organisational group, with expects in the field of Sepsis, are currently working on this project.

The guidance will be based on the clinical analysis sequence, and consists of three questions:

- Is the patient sick?
- Does the patient have an infection?
- What is the degree of urgency in specific components of treatment? (including time to antimicrobials)

We have chosen to develop a clinical pathway with NEWS as the entry point. Taking into account clear guidance, clinical judgement and including flexibility on antimicrobial prescribing. We plan an electronic format with pop-ups or hyperlinks. This will be piloted and consulted upon before release.

CAREERS, RECRUITMENT AND WORKFORCE

Dr Daniele Bryden
Chair: Careers, Recruitment and Workforce Committee (FICMCRW)

Writing this in the 'new normal' of living and working with COVID, uncertain what the coming winter will bring for the NHS, I've been reflecting on the CRW Committee and its role in the Faculty. It's relatively easy in healthcare to produce short term outputs with great fanfare (although these have a place in setting the ball rolling), but real development takes time to create and establish. COVID exposed the issues of historical critical care under provision, and the Faculty's 2017 Critical Futures initiative, is now providing a route map for future working e.g. Enhanced Care. 'Mutual aid' became the means by which we addressed the initial crisis, but cannot be a reliable way of addressing longer term issues like staffing deficiencies, without identifying what benefits might come from mutual aid in the future.

Going forward, CRW will play an important role in the Faculty's leadership and influence in critical care service related changes. The Committee has been refreshing and reviewing work already underway in light of what is needed now to plan for future services. The refreshed workforce databank will give you the national and regional information for business cases; unfortunately we will not be sending out a census this year but, we are aiming for the next census to go out to Clinical Leads in early 2021. This will give the information we all need to continue to make the case for new posts and service development.

Members of the CRW Committee are good at foresight, exploring ideas that have been 'bubbling under' mainstream ICM notice and developing some of them into bigger projects such as highlighting the vital role of IMG doctors and the benefits that come from developing this group. It is particularly exciting to welcome our new pharmacist members into their own Faculty subcommittee, alongside our ACCP members, as this allows the Faculty to work with our pharmacy members to address their professional workforce needs.

I am handing over as Chair of CRW to Jack Parry-Jones. The Committee's portfolio grows, its membership flourishes and Jack will undoubtedly nurture new projects. Thank you to all CRW members, past and present for your hard work and commitment.

RECRUITMENT UPDATE

Dr Tim Meekings
Recruitment Lead

At the time of writing, the first wave of the COVID-19 pandemic surge to hit the UK appears to have passed, and the tireless critical care workforce that weathered this storm anxiously await any future surges. As the pandemic arrived and spread through the population, it became apparent that we simply could not proceed with the normal interview process for national ICM recruitment; to do so would pose an unacceptable risk to the applicants, interviewers and Health Education England (HEE) staff. Besides, the critical care workforce was urgently needed all around the UK to staff escalating resident rotas to help counter the pandemic.

In the absence of the usual interview process, critical decisions were required around how to undertake an ICM recruitment process without the ability to meet the applicants face to face. Although the option of some sort of video link-up to interview candidates remotely was explored, the technical requirements for this and the likelihood of a much longer interview process meant that this was going to be impossible to successfully implement in the short timescale available. This was particularly the case with a pool of Consultant Intensivist interviewers who were being pulled into increasing commitments to frontline clinical work and ongoing urgent planning and preparation for a growing pandemic that had not yet even begun to peak. The only option to even attempt national ICM recruitment this year was to rely upon the information that applicants had already supplied as part of the recruitment process.

The self-assessment portfolio score had been provided by each applicant, and this became a way to stratify over 400 applications whilst deciding how to set a standard by which an applicant could be deemed to be appointable. A group of experienced ICM interviewers, in consultation with HEE, decided upon a minimum standard for the self-assessment portfolio; this was a judgement made by looking across each domain to determine the minimum standard for applicants and also in view of the previous year's scores, to see how candidates' scores in the portfolio self-assessment had previously matched up with their overall score on the day of interview.

This year, of the 404 applicants who fulfilled the essential criteria for appointment, 379 were deemed to have a high enough self-assessment score to be appointed and therefore were put forward to the matching process around the UK. Fortuitously, in recognition of the vital need to maintain a stable ICM workforce into the future, HEE granted an additional 114 ICM training posts this year across the UK (100 in England, 4 in Wales, 6 in Scotland and 4 in Northern Ireland). This meant that there was a total of 289 ICM training posts available in 2020; of these 97% were successfully filled, giving us the biggest cohort by far of newly-appointed ICM trainees this year. Of course, the challenge will now be to support and guide this vital new workforce as they gain experience and progress towards a CCT in ICM.

The national ICM recruitment round for 2021 is just around the corner. As part of the planning and preparation, we will be looking at different ways to deliver this. Depending on the progress of the pandemic, face to face interviewing (with social distancing) may or may not be a safe way to hold the interviews. If not, with more time to prepare, we can look at various ways of achieving a more remote process with the use of technology and some adjustments to the format. Look out for updates on the Faculty website and Twitter. Whatever the future holds, we will continue to recruit a diverse, enthusiastic and talented workforce to train in our expanding and increasingly important specialty.

ADVANCED CRITICAL CARE PRACTITIONERS

Ms Carole Boulanger
Co-Chair: ACCP Sub-Committee

Dr Simon Gardner
Co-Chair: ACCP Sub-Committee

It's been an eventful period all round in ICM with the challenges of COVID-19 and all it brought. ACCPs both trained and in training proved their position as part of the workforce, managing patients and supporting the rapidly changing requirements of the ICU team. We would like to acknowledge and thank ACCPs for their contributions to the whole team during this period. In conjunction with Brunel University and HEE, we are participating in a study to collect the experiences of ACCPs and Consultant Practitioners based in English Intensive Care departments during the pandemic. This should provide a useful insight into the deployment of the role during this period.

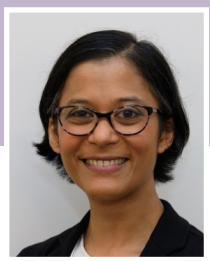
COVID necessitated a pause to some of the FICMASC projects, which are all now back on track. We sadly had to postpone our annual conference due to be hosted by Newcastle. We are hoping to be back in Newcastle on 3rd June 2021 for next year's conference.

The FICM Board approved Higher Educational Institution (HEI) Accreditation by the FICMASC. This process has been agreed and, pending some changes to reflect social distancing arrangements, we will proceed to call for interest in the coming months. This is an important step for us in ensuring the quality standard of education for trainee ACCPs. We have several HEIs interested, which will support the hub and spoke training model well.

We have resumed our discussions with HEE and the advanced practice agenda. HEE have granted some funding to FICM to participate in a health economics study and a general publicity project; we will release more information on this when we have it. To assist in navigating the minefield of advanced practice roles, we have produced a FICM equivalence pathway and the routes to reach FICM ACCP membership status. https://www.ficm.ac.uk/training/accp-member-equivalence-pathway.

The FICMASC has been working to develop Optional Skills Framework (OSF) modules for ACCPs to undertake as appropriate post core training. The modules reflect the expansion and development of additional skills by ACCPs in local settings, based on service need. The first of these, Diagnosing Death for Donation after Circulatory Death (DCD) created in conjunction with NHS Blood and Transplant, has just been released. The decision to undertake these OSFs rests with the local units and the ACCPs involved. They provide a national FICM recognised knowledge, skills and competency based framework which will standardise practice across the UK. It is envisaged that there will be a range of OSFs eventually available, the next in progress is in Advanced Airway Management followed by an OSF in ACCP led transfer of critically ill patients thanks to active involvement in the National Transfer Project. All OSFs have at their core a key component of governance and risk management to ensure the safety of patients and the ACCPs themselves. These are not new skills for a proportion of ACCPs who have been performing them to a high standard for some time.

We are delighted to welcome some new ACCPs to the FICMASC, Rick Faulkner, Bill Allen and Natalie Gardner were successful in their applications to join the group. We very much look forward to working with them to continue the expansion and further development of the role.



WICM UPDATE

Dr Rosie Baruah
Chair: WICM

The WICM sub-committee has been progressing its workstreams, despite the constraints of the COVID-19 pandemic.

Last year's 'Striking the Balance' held in September was a great success, with very positive feedback indicating a real need for this kind of meeting. The next 'Striking the Balance' event will be themed around 'psychological safety in the ICU' and will follow a similar format to the inaugural meeting, with a morning of talks and an afternoon of interactive workshop sessions. The original date was November 2020; we haven't yet rescheduled this as it is still unclear when the pandemic will subside sufficiently to allow mass gatherings of intensivists!

We are very excited to launch our mentoring scheme, 'FICM Thrive' later this year. The scheme will initially be aimed at mentoring consultants within five years of appointment. We will be putting out a call for volunteer mentors later in the year; many of you indicted an interest in acting as a mentor when we sent out a scoping questionnaire and we will be in touch with all those who gave their email contacts. This phase of FICM Thrive is intended to act as a pilot project, and participants will be asked to give feedback to allow us to fine tune the scheme before opening it up to the whole FICM community.

The first cohort of FICM Emerging Leaders have been making the most of their Fellowships despite the current constraints. Each Fellow has had the opportunity to attend a variety of FICM committee meetings of their choice, complete an Open University Leadership module, and reflect on their learning with a Board mentor. They have also taken turns to chair a Fellows meeting, giving them valuable chairing experience. The Fellows were due to have their wrap up day in July; this has now been deferred to autumn and will take place virtually.

WICM now has an established and strong presence on Twitter; if you don't already follow us, we are at @WomenICM. In March we ran a Twitter campaign called #IAmALeader, highlighting the incredible leadership skills we have in our women doctors in training. We have regular #WICMWeeks, where a woman in ICM will give an insight into her working week, in and out of the ICU. We also have a regular blog spot at ficmlearning.org.

This is my last Critical Eye article as Chair of WICM. After three brilliant years chairing this incredible group, I am stepping down to start an MD investigating the potential barriers to careers in ICM for women. I am delighted to be able to announce that Liz Thomas is the new Chair of WICM, and Sarah Marsh will continue as Deputy Chair. I would like to thank the members of WICM for their hard work, along with Susan Hall, Lucy Rowan, Daniel Waeland and Danny Bryden for their support and guidance.

TRAINING AND ASSESSMENT

Dr Chris Thorpe
Chair: Training, Assessment & Quality Committee (FICMTAQ)

By the time you read this article, I will have chaired my first Training, Assessment and Quality Committee meeting. I would like to say a big thank you to the outgoing Chair, Tom Gallagher, for all of his hard work over the last few years. You would have thought that once a training system was in place things should run reasonably smoothly but it's amazing how many unpredictable dilemmas there are to deal with. This is intrinsic in any system involving many components. Here are a couple of pertinent examples:

The FICM Medical Secretary Role

Most training issues are dealt with regionally; any queries about training that the RA/TPD cannot resolve locally come to the medical secretary (now me), who can make a judgement, alongside Rohini (the Faculty's Training and Examinations Administrator) based on regulations and previous examples (if there are any). If the issue is complicated, it goes to the TAQ committee for discussion. We are bound by the GMC to honor the detail in our curriculum so some requests simply cannot be granted, as the training for that particular trainee could potentially be invalidated.

A New Curriculum

The 'Shape of Training Review' and the GMC's 'Excellence by design: standards for postgraduate curricula' provided an opportunity to reform postgraduate training to develop a workforce fit for the needs of patients, producing a doctor who is more patient focused, more general and has more flexibility in career structure as recommended by the GMC document 'Adapting for the future'. These documents have triggered all medical colleges to revise their curricula and incorporate interchangeable and consistent generic professional capabilities at the forefront. Cue large amounts of work, which has been undertaken by the FICM Curriculum Subcommittee.

The process really did involve a huge amount of man-hours and presented another problem. The new Internal Medicine (IM) curriculum mandates that Respiratory, Renal and Acute Internal Medicine (AIM) trainees must

also dual accredit in Internal Medicine. Both the Royal College of Physicians (RCP) and the FICM are in absolute agreement that these physicians should be able to train in ICM, as has always been the case. In order for this to continue, it would necessitate a triple CCT, or an exception to the IM dual curriculum to allow dual training with ICM. The RCP is very keen for the dual with IM to be in place for all trainees to reverse some of the silo approach that interferes with general medical care, and are concerned that there are knock on effects for the physicians if we make ICM an exception to this rule. The triple CCT would add a short extra time of training.

We recently attended a meeting with GMC Curriculum Oversight Group (COG) and the RCP, with Mike Jones (my equivalent in the RCP) and myself making some headway. The COG was set up by the GMC with the responsibility of organising and approving the curricula for all specialties. It is made up of medical educationalists from the UK Medical Education Reference Group, and is the key decision maker for these kinds of issues. It is fair to say that COG were definitely supportive of trainees in the physician specialties continuing to have the option to train in ICM; how this will be achieved is still under discussion. Rest assured that we are committed to continue to train the physicians who add so much to our specialty.

Finally, we are very much aware of the impact that COVID-19 has had on trainees, trainers and all that are involved in organising training. We are keen to be as flexible as possible to minimise any concerns and, to that effect have arranged with the GMC for unavoidable changes to training to be accommodated through agreed derogations that encompass different orders of training and exam difficulties. The current derogations are currently valid until March 2021. This is a moving target, and we will have to keep on top of this as time goes on.

TRAINEE UPDATE

Dr Richard Benson
Lead Trainee Representative

It is hard to envisage where we might be when you read this. It is perhaps easier to reflect that the last six months have been difficult. We have seen escalation of rotas, cancellation of examinations, redeployment and changes to recruitment. Your response as trainees to this has been phenomenal. Thank you!

With the transition to the next phase we need to make sure that you are supported. One of the priorities has been to ensure that training can progress and examinations can take place safely.

Recent ARCPs have included the new COVID-19 specific outcomes (10.1, 10.2). This reflects the fact that COVID-19 will have affected training and that wherever possible, progression through clinical training should continue without detriment to the trainee. They are 'no fault outcomes' and should be viewed as such.

The next sitting of the FFICM exam will be in October. There is a strong desire from trainees, the statutory education bodies and the Faculty that everything is done to ensure that this takes place. Given the potential for further local lockdowns and disruption to travel, the exam has been moved to an online format. Having recently spent the afternoon with fellow advanced trainees and Consultants trialling this format, I can reassure you that it does work. Best of luck to all for the upcoming sitting.

In the midst of the pandemic, recruitment to ICM took place and it is great to welcome so many new ICM trainees. I know that recruitment this year was abnormal with the cancellation of interviews but, it is fantastic that we can still welcome a new cohort and continue the ongoing growth of our specialty.

There has been understandable concern from trainees about the ability to potentially undertake dual training with medical specialties in the future. Fortunately, forward progress with this has been made. The GMC has welcomed submission of a training model which would enable trainees to dual train in ICM or Internal Medicine with AIM, Renal Medicine or Respiratory Medicine. This is an important step forward to protecting the diversity of our profession.

The next few years are likely to see considerable changes to the way in which healthcare care is delivered. Trainees are at the forefront of clinical care and we will have an important part to play in this. It may be tough for us all but please do reach out. Utilise your support networks; fellow trainees, Consultants, Faculty Tutors, your Regional Advisor and the Faculty.

We are here to support you.

FICM Deputy Trainee Representative Election

Notice is hereby given that an election for the FICM Deputy Trainee Representative will be held on **29 October 2020**.

Candidate details will be published on the FICM website and an online voting link will be sent to all trainees in early October.

The elected candidate will take office at the Board Meeting on 13 January 2021.

REGIONAL ADVISOR UPDATE

Dr Sarah Clarke
Lead ICM Regional Advisor

Who could have anticipated the tumultuous life-changing, global events which have occurred this year? As I write this in July, we are in the lull before 'who knows what?' of a second surge of the COVID-19 pandemic, and hopefully colleagues and friends alike are taking well-deserved and needed rest and downtime. As we reflect on the last few months, and take time to remember all those who suffered or lost their lives during the COVID pandemic, I am constantly reminded of how proud and humbled I am to be part of this amazing specialty, and the multi-disciplinary team it is.

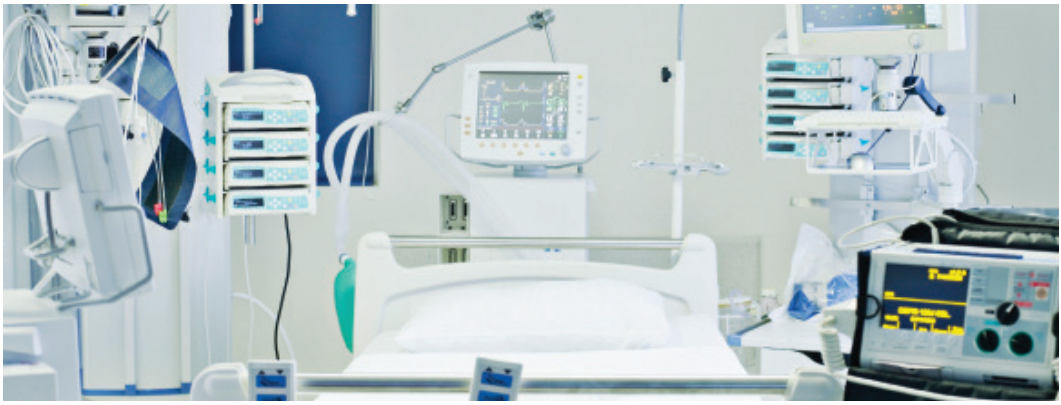
Aside from their clinical coal-face activities, the RAs have continued to deliver on their training and education commitments with reliable and understated dedication. As Lead RA I could not have got through the last few months without their support and encouragement. Following the HEE supported decision to cancel face-to-face national ICM recruitment (in line with all other Colleges), the Faculty were keen that already-stressed applicants were not disadvantaged or discounted from entering ICM training. Add into the mix (and a very short consultation) the RAs embraced an additional 114 training numbers (on top of the existing 175) funded by HEE, spread across the four nations. This is truly an amazing step in our evolutionary pathway. Further work continues to repeat that funding for successive recruitment rounds. Dare I say, I might hope that the additional workforce deployed during COVID, from medical students, iFYs, Foundation Doctors, core trainees have had a taste of ICM and want to apply in future years!

So, what of our existing trainees and colleagues who have worked alongside us; through the darkest days, on the general ICU floor, in COVID zones, green pathways, non-clinical, and those shielding? Each one deserves a huge thank you. All have helped keep the wheels turning, to ensure training continued, paperwork signed, portfolios checked, competencies met, and wellbeing supported. Following GMC-approved derogations and the FICM ARCP Decision-Aid, the RAs have sought to ensure that each and every trainee practicing ICM has been able to prepare for their ARCP and achieve appropriate and progression-enabling ARCP outcomes. For our colleagues who do not have ICM in their curricula or PDPs, we are encouraging you to use the 'COVID PASSPORT' sign-off to support skills and abilities attained during deployment. More information can be found here.

The RAs met 'virtually' in September. Hearing how my fantastic colleagues manage their regions (local solutions for local problems) is always something I look forward to. Already they have submitted their annual reports, and they must be thanked for their solid reliance. They've continued throughout to approve and monitor new Consultant Job Plans, attend ARCPs, coordinate with STCs, represent the Faculty at Trust, regional and national level. Most importantly they continue to support trainees in success, in need, and in every aspect of the specialty.

By the time this edition of Critical Eye is published, the GMC will hopefully have approved the curriculum rewrite. This is a great achievement, and fantastic piece of work by the Curriculum Working Party. Now our role as RAs is to support our trainees, Faculty Tutors and Educational Supervisors as we adopt the new curriculum, hopefully ensuring a simplified, streamlined version is suitable for the trainee and trainer of tomorrow.

In closing, I want to give top thanks to Matt Williams, the Deputy Lead RA, for his calming influence and sense checks. I say thank you and cheerio to our outgoing RA and a big welcome to our new RA appointments: what a baptism of fire 2020 is!



PROFESSIONAL AFFAIRS AND SAFETY

Dr Peter Macnaughton
Chair: Professional Affairs and Safety Committee (FICMPAS)

COVID-19 has unsurprisingly impacted on the work of the Committee and has been the focus of activity in recent months. Committee members have been active in contributing to the range of guidance published on the joint COVID site. (icmanaesthesiacovid-19.org). Personally, one undoubted benefit of COVID-19 has been the move to videoconferencing and the realisation that business can be conducted effectively without face to face meetings. Being based in the South West, I did not relish the early starts for a three-plus-hour train journey to London for a meeting.

The safety work of the committee has continued throughout the pandemic. A key element of the activity has been the establishment of a data sharing agreement with NHS Improvement who host the National Reporting and Learning System (NRLS) database that collates data on all patient safety incidents. This work is being led by Prof Gary Mills and will allow analysis of safety incidents involving critical care with the aim of wider sharing of lessons.

As work is returning to some sort of new normal, projects that have been on hold are now being reactivated. One of these is working with the ACCP Sub-Committee to develop a module to allow ACCPs to develop advanced airway skills. It is a sign of how far we have come, as I doubt this would have been supported a few years ago. ACCPs are now firmly established in many units where they have become essential and highly valued members of the critical care workforce supporting resident medical rotas. GPICS V2 alluded to suitably trained ACCPs being able to provide advanced airway skill support for critical care units and the module will encompass competencies to manage emergency intubation including unexpected extubation in ICU, provide advanced airway skills for the the transfer of intubated patients and airway management during percutaneous tracheostomy. This will support an enhanced role for ACCPs which is likely to drive the establishment of ACCPs in many other units.

ENDOTRACHEAL TUBE REVISION ON THE ICU

Prof Gary Mills

FICM Professional Affairs and Safety Committee, Safety Lead

Endotracheal intubation on the intensive care unit has been an area that has received attention over recent years, especially following the findings of NAP4, which highlighted the additional dangers posed by intubation in the critically ill. This was followed by a *Guidelines for the management of tracheal intubation in critically ill adults.* This has led to the widespread adoption of checklists for intubation and attention to the hazards of extubation. Key to this is advanced planning, preparation and consideration of the DAS guidelines.

Patients on the ICU are vulnerable, because of their reduced respiratory and cardiovascular reserve. What, at first intubation, may have been a relatively straightforward airway, may have developed oedema due to critical illness, prolonged intubation or prone positioning, as well as other issues such as complications of surgery or burns that make later reintubation much more difficult. The patient's ability to maintain an adequate oxygen saturation and gas exchange may be already impaired, combined with a risk of cardiovascular instability. Unexpected extubation remains a common and difficult area, as does a change of endotracheal tube sometimes for leaks or occlusion, or a less urgent need such as to provide a suitable endotracheal tube for subglottic suction.

The majority of airway incidents occur on ICU in patients who have had their airway secured, either by an endotracheal tube or via a tracheostomy. An urgent need to reposition or replace an endotracheal tube can occur at any time of day, sometimes with no advanced warning of the loss of airway.

Recently there has been an example of a revision of an endotracheal tube over a bougie in a patient with ARDS on ICU, which resulted in a 'can't intubate can't oxygenate' (CICO) situation, eventually leading to hypoxic brain injury.

The incident highlighted to staff the need for a safety checklist in a change/revision of tube situation and a recognition that endotracheal tube revision in the critically ill is a high risk procedure that requires the immediate availability and planning for a CICO scenario. They determined there was a need for regular training of staff in how to deal with this situation, together with consistent communication, recognition and anticipation of hazards. Preparation and planning, with immediate availability of comprehensive and familiar equipment including videolaryngoscopy and fibreoptic bronchoscope availability, combined with consideration of a Vortex approach were considered vital.

This is a reminder that careful consideration of all aspects of airway care and airway emergencies on the ICU, especially arising in patients who are currently intubated is important, especially as we learn lessons from unfamiliar situations during the care of the critically ill patient in the Covid-19 pandemic and as we prepare for what the future will bring.

To this end, we will be launching a regular bulletin and analysis of critical care incidents to highlight hazards encountered during the care of the critically ill as well as our current safety and ViRUS updates.

If you would like to see references which accompany this article, please contact the Faculty at contact@ficm.ac.uk.

LEGAL AND ETHICAL POLICY UNIT

Dr Chris Danbury

Chair: Legal and Ethical Policy Unit (LEPU)

With no surprise, COVID-19 has filled the year for LEPU. We have welcomed Lauren Sutherland QC onto the group, representing the legal profession in Scotland. Readers will be aware that Lauren was the advocate who took Nadine Montgomery's case to the Supreme Court. It is fantastic that we have been able to persuade her to join us. LEPU feels that it is important to try to get representation from all jurisdictions within the UK as the law is subtly (and sometimes not so subtly) different. Examples of this include the Bolam test in England as opposed to the Hunter v Hanley test in Scotland. Similarly, the Mental Capacity Act 2005 applies to England and Wales, Scotland follows the Adults with Incapacity (Scotland) Act 2000 and Northern Ireland follows the Mental Capacity Act (Northern Ireland) 2016. Trying to provide guidance in our Midnight Law series, whilst respecting the different jurisdictions is a tricky process. My thanks to the lawyers on LEPU: Lauren, Alex Ruck Keene and Ben Troke for keeping us from making errors in the Midnight Law series.

Going back to COVID-19, there has been a fantastic response from the intensive care profession with a significant amount of work done by a variety of stakeholders to produce guidance to help clinicians. The BMA, RCP, ICS, GMC and NICE have all produced useful pieces. LEPU and the Faculty took the view that it was important to work with the national bodies to produce guidance rather than produce our own. Having yet another organisation write something slightly different might be construed as mudding the waters. In addition, it is not clear precisely where different responsibilities lie. A blog written by George Thomas, Katie Gollop QC and Sophia Roper is a worrying summary of how unclear the law is in regards to treatment limitation decisions particularly when they come into conflict with resource allocation http://ukmedicaldecisionlawblog.co.uk/rss-feed/119-covid-19-allocation-and-withdrawal-of-ventilation-the-urgent-need-for-a-national-policy.

I share their view that national guidance from the Department of Health would be extremely useful. This is not to take anything away from various groups who have written extensively on the subject, but that anything short of government derived guidance may leave individual clinicians being held directly liable for extremely difficult decisions. This is something we all want to avoid.

The Midnight Law series continues to grow. We aim to publish a new one every six months. The latest is about Child Protection/Safeguarding and can be found here: https://www.ficm.ac.uk/sites/default/files/midnight_law_child_protection_safeguarding-_may_2020.pdf.

We discussed the rise of web conference calls, but felt that the Information Commissioner is best placed to cover this area.

I'll finish with my usual comments about benefits of mediation. In a recent case, Great Ormond Street v MX, FX and X [2020] EWHC 1958 (Fam), Ms Justice Russell DBE said at 59, "… the Court had to insist that mediation was imperative, both to assist in narrowing the issues to be decided, and to reduce the levels of distress for this family…" In this case, the issues were narrowed by mediation and various non-medical commentators have noted that this is an excellent example of mediation helping.

I hope that everyone has a safe second half of the year and that any new wave of COVID-19 is only a very small one.

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